Background Questionnaire

Child's full name: _____ Child's preferred name: _____

Child's date of birth: _____ Age: _____ Sex: □ Female □ Male □ Other: _____

Preferred pronoun: □ He □ She □ They □ Other: _____ Handedness: □ Right □ Left □ Neither □ Both

Child's first language: □ English □ Other: _____ Languages spoken at home: _____

Person completing this form: _____ Relationship to child: _____

Who has legal custody of your child? □ Joint/Both □ Mother □ Father □ Other: _____

Referral Information

Who referred you for this evaluation? _____

What are your main concerns about your child? _____

What are your child's strengths? _____

Family Information:

List people currently living in your child's household (please include siblings living outside of the home):

Name:	Relationship:	Age:	Highest Education :	Occupation:

If your child does not live with either biological parent, what is the reason? _____

Are there any current family stressors, changes or recent losses? _____

Family Medical History: Please indicate if there is a biological **family history** of any of the following (check all that apply and if **yes**, please write the family members' relationship to your child):

	Condition	Relationship to Child		Condition	Relationship to Child
□	ADHD/ADD		□	Epilepsy	
□	Alcoholism		□	Genetic Conditions	
□	Alzheimer's Disease		□	Head Injury	
□	Anxiety		□	Hydrocephalus	
□	Autism/Asperger's		□	Language Disorder	
□	Bipolar Disorder		□	Learning Disability	
□	Cancer		□	Multiple Sclerosis	
□	Cerebral Palsy		□	Psychiatric Hospitalizations	
□	Cognitive Impairment		□	Schizophrenia	
□	Concussion		□	Seizures	
□	Depression		□	Stroke	
□	Dementia		□	Suicide completion	
□	Developmental Delay		□	Suicide thoughts or attempt	
□	Problem drug use		□	Tobacco Use	
□	Dyslexia		□	Other:	

Please briefly provide details for any conditions you marked above: _____

Your child's birth history:

Length of Pregnancy: _____ Birth Weight: _____

Delivery: □ Vaginal □ Planned Cesarean Section □ Emergency Cesarean Section

Were there complications during the pregnancy: □ No □ Yes (Explain): _____

Were there complications during delivery or immediately after birth: □ No □ Yes (Explain): _____

During pregnancy, did the mother of this child:
Take any medications □ No □ Yes: _____
Use recreational drugs □ No □ Yes: _____
Drink alcohol □ No □ Yes
Smoke cigarettes: □ No □ Yes

At what age did your child:

Crawl: _____ Use single words meaningfully: _____

Walk: _____ Use two-word phrases meaningfully: _____

Toilet trained by day: _____ Toilet trained by night: _____

Has your child ever received Early Intervention or Birth to Three Services? □ No □ Yes
(Details): _____

Child's Medical History: Does your child have a history of (check all that apply):

	Condition	Age		Condition	Age
□	Alcohol Use		□	Hearing problems	
□	Allergies		□	Hydrocephalus	
□	Anxiety		□	Language Disorder	
□	ADHD/ADD		□	Lead Poisoning/ Elevated Lead Level	
□	Asthma		□	Learning Disability	
□	Autism/Asperger's		□	Loss of Consciousness	
□	Brain Injury		□	Medical Hospitalizations	
□	Behavioral Problems		□	Meningitis	
□	Cancer		□	Multiple Sclerosis	
□	Cerebral Palsy		□	Problems with Peers	
□	Cognitive Impairment		□	Psychiatric Hospitalizations	
□	Concussion		□	Seizures	
□	Depression		□	Self-Harm/ Self-Injury	
□	Developmental Delay		□	Sleep problems	
□	Diabetes		□	Stroke	
□	Recreational Drug Use		□	Suicidal thoughts	
□	Dyslexia		□	Surgery	
□	Ear infections		□	Tobacco Use	
□	Genetic Conditions		□	Vision problems	
□	Headaches		□	Other:	
□	Head Injury				

Please briefly provide details for any conditions you marked above: _____

Please list any medications your child is currently taking. Include prescriptions, over the counter medications and previous medications:

Drug	Currently Taking	Date started	Dose/Frequency	Reason
	□ Yes □ No			
	□ Yes □ No			
	□ Yes □ No			
	□ Yes □ No			
	□ Yes □ No			
	□ Yes □ No			
	□ Yes □ No			
	□ Yes □ No			

Psychosocial History:

Has your child ever had any of the following types of evaluations? (Check all that apply and provide details)

Please bring copies of any previous evaluations to your clinic appointment.

	Type of Assessment	Date	Provider's Name	Contact
□	Educational/Psychoeducation			
□	Neurology			
□	Neuropsychology			
□	Psychology			
□	Physical Therapy			
□	Occupational Therapy			
□	Speech/Language Therapy			

Has your child ever seen a psychiatrist? □ Yes □ No Dates: _____

Has your child ever been seen by a psychologist? □ Yes □ No Dates: _____

Has your child ever participated in counseling/therapy? □ Yes □ No Dates: _____

If yes, please provide the name(s) and contact information: _____

Has your family had any involvement with Child Protective Services? □ Yes □ No □ Prefer Not to answer

Educational History

Name of current school: _____ Current grade: _____

Has your child ever repeated a grade? □ Yes □ No Which grade(s): _____

Has your child ever been suspended or expelled? □ Yes □ No Dates: _____

Has your child ever received special education services (e.g., Individualized Education Plan) □ Yes □ No Dates: _____

Has your child ever received accommodations (e.g., 504 Plan) □ Yes □ No Dates: _____

If Yes, please briefly describe the IEP or 504 services or accommodations: _____

Please provide any additional comments or information: _____